Valley Institute of
Primary Medical Care
of Alabama

2828 HWY 31 S • Suite 104
Decatur, AL 35603
Phone: (256)909-4004 • Fax: (256)909-4564

New Patient Packet

Dear Patient,

Thank you for choosing Valley Institute of Primary Medical Care of AL, we look forward to providing you with excellent care. Enclosed you will find our New Patient Forms. Please fill these forms out completely prior to your appointment and return them by fax, mail, or in person.

At your first visit, please bring the following:

- Completed New Patient Forms (If you have not already submitted them)
- Your Photo ID
- Your Insurance Card(s)
- The bottles of all your medications, both prescription and over-the-counter medications (not just list, please bring the actual bottles)
- If the patient is a minor, bring vaccinations record
- You will be responsible for your co-pay at arrival

We ask that all new patients arrive at least 15 minutes early, so that we can confirm your medical history information.

If you are unable to keep your appointment, or need to reschedule for any reason, we ask for a minimum of a 24-hour notice.

Our waiting room is open with limited seating, and we ask that only the patient enter the clinic unless a visitor is needed to assist the patient. If you are more comfortable waiting in your car, please let us know at check-in, and we will call you once we have your room ready.
Please wear a mask while inside the clinic.

Sincerely,

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Privacy Policies

Valley Institute of Primary Medical Care of AL, LLC is committed to protecting your health information.

This Notice of Privacy Practice describes the personal care, treatment, and billing information we collect for your medical record and how and when we may use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information:

Each time you visit VIP Medical Care of AL, a record of your visit is made. Typically, this record contains your symptoms, examinations, test results, diagnosis, treatment, and plan for future care or treatment. This information, often referred to as your medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care. This may include, but is not limited to physicians, nurses, medical assistants, technicians, staff, and other personnel utilized by our practice.
- Legal document describing the care you received.
- Means by which you or a third-party payor can verify that services billed were provided.
- A tool in educating health professionals.
- A source of data for medical research.
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our business planning
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understand what is in your record and how your health information is used helps you to:
Ensure its accuracy
Better understand who, what, when, where, and why others may access your health information
Make informed decisions when authorizing disclosure to others.

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Your Health Information Rights:

You have the following rights regarding your Medical Record:

- Inspect and copy your health information including medical and billing records. We require in writing and will respond to this request within 14 business days. We have legal right to deny this request for specific limited circumstances. You have the right to request an appeal of a denied request. Also, a reasonable fee can be charged, as allowed by law, for copies of your record.
- Request an amendment to your records if you feel they are incorrect or incomplete. Request must be made in writing and must contain information that supports your request. We must respond to an amendment request within 30 days. We have the right to deny a request if we do not feel your request is supported, if we feel the original documentation is accurate and correct or if the information was not originally created by us.
- Obtain an accounting of certain disclosures of your health information. The right applies to disclosures for purpose other than treatment, payment, or healthcare operations only.
- Request communications of your health information. The right applies to disclosures of your information. This request must be in writing to VIP Medical Care of AL, and must include specific restrictions of uses and/or disclosures to whom and of what information. We are not required to provide you with emergency care or required by law.
- Obtain a paper copy of this notice of information practices upon request at any time.
- Detailed information regarding these policies are available and questions can be directed the Privacy Office.

Our Responsibilities:

VIP Medical Care of AL is required to:

- Maintain the privacy of your health information and provide you with this notice (upon request) as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of the Notice of Privacy Policies currently in effect.

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Consent For Treatment and Conditions of Treatment

Consent For Treatment:

- This is my authorization and consent for care and treatment by Valley Institute of Primary Medical Care of AL and its agents. I acknowledge that no guarantees have been to rue as to the effect of such examination or treatment on my condition.

Personal Valuables:

- I acknowledge that Valley Institute of Primary Medical Care of AL shall not be liable for the loss or damage to any personal property.

Permission for Disclosure of Information:

- This authorizes Valley Institute of Primary Medical Care and its representatives and employees to release all information, including, but not limited to copies of medical and other records relative to this treatment, testing, and diagnosis to all insurers, third party payors, and other health care institutions or entities involved in patient transport or continuing patient care, CAMPUS, physicians or agencies performing review functions authorized by contract, law, or regulations.

Financial Agreement and Assignment of Insurance Benefits:

- The undersigned agree(s), whether signing as agent or as patient that in consideration of services to be rendered to patient, the undersigned is obligated to pay for the same in accordance with the regular rates and terms Valley Institute of Primary Medical Care of AL, and that should the account be referred by Valley Institute of Primary Medical Care of AL to and attorney or collection agency for collection, the undersigning shall pay all reasonable fees, interest, and costs of collection. Further, the undersigned waives as to this debt all rights of exemption under the constitution and laws of Alabama or any other state as to his personal property.
- In event the undersigned and/ or patient is entitled to benefits of any type, whatsoever, arising out of any Insurance or any other party liable to the patient, then the undersigned assigns such benefits to Valley Institute of Primary Medical Care of AL. The undersigned hereby authorizes and directs that all insurance benefits assigned shall be paid directly to Valley Institute of Primary Medical Care of AL for respective services rendered. The undersigned and/or patient agrees and understands that acceptance of Insurance coverage is conditional until insurance pays and all charges not paid by insurance are the responsibility of the undersigned and/or patient.
- The undersigned and/or patient is responsible for the compliance with any precertification and/or other requirements of any Insurance company or third-party payors. The undersigned and/or third-party payors versus that of the medical provider.

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Statements to Permit Payment of Medicare/Medicaid Benefits to Provider:

- The undersigned and/or patient certifies that the information given by him/her in applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. The undersigned and/or patients requests that payment of authorized benefits be made to Valley Institute of Primary Medical Care of AL for any services furnished to him/her. The undersigned and/or patient authorizes any holder of medical or other information about the patient to release to Health Care Financing Administration, the State of Alabama, their Intermediaries carriers or agents any information needed to determine these benefits or benefits related service.
- It is understood that the undersigned and/or patient is responsible to Valley Institute of Primary Medical Care of AL for any health insurance deductibles and coinsurance.
- The undersigned and/or patient certifies that he/she has read the forgoing and agrees and accepts same.

_____	_____	_____
Policy Holder	Patient/Representative Relationship	Date
_____	_____	_____
Policy Holder	Patient's Agent or Representative	Date

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Authorization for Release of Information

Patient Name:_____ Date of Birth_____
Address: _____City _____ State: _____ Zip:_____
Phone Number: _____
Guardian or POA Name: _____Phone Number:_____
I hereby authorize Valley Institute of Primary Medical Care of Alabama to: _____ Release To and/or _____ Obtain from the following information pertaining to my care and/or treatment:

Release To or Obtain From: Practice/ Provider _____
Address: _____
Phone Number: _____ Fax: _____
Include the following information:

____ Progress Notes ____ History & Physical ____ Labs
____ Immunization Records ____ Discharge Summary ____ Pathology Reports
____ Referrals ____ Imaging Reports ____ ER Reports
____ Entire Medical Record ____ Other _____

Purpose of Disclosure: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service, and treatment for alcohol or drug abuse.

I authorize the use or disclosure of my personal information (PHI)m as described. I understand that the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal privacy regulations.

Revocation: This authorization to release confidential information may be revoked by me, in writing, at any time, except the extent of action has already been taken. Written revocation should be provided to VIP Medical Care of AL at the above address.

I understand that authorizing the disclosure is voluntary. I can refuse to sign the authorization. I need not to sign this for in order to assure treatment. I understand I may inspect or copy the information to be used on disclosure as provided in CFR 164.524. If I have questions about disclosure of my health records, I may contact VIP Medical Care of AL at the number above.

_____ _____ _____
Patient or person authorized to sign for patient Date Time

_____ _____ _____
Witness Date Time

Reason patient is unable to sign